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ABSTRACT

Rodger L. Hurley discusses the causal relationship between poverty and mental retardation; John W. Kidd describes limitations in special education systems. Also, David L. Cowen considers health problems and health care of the poor. (JD)

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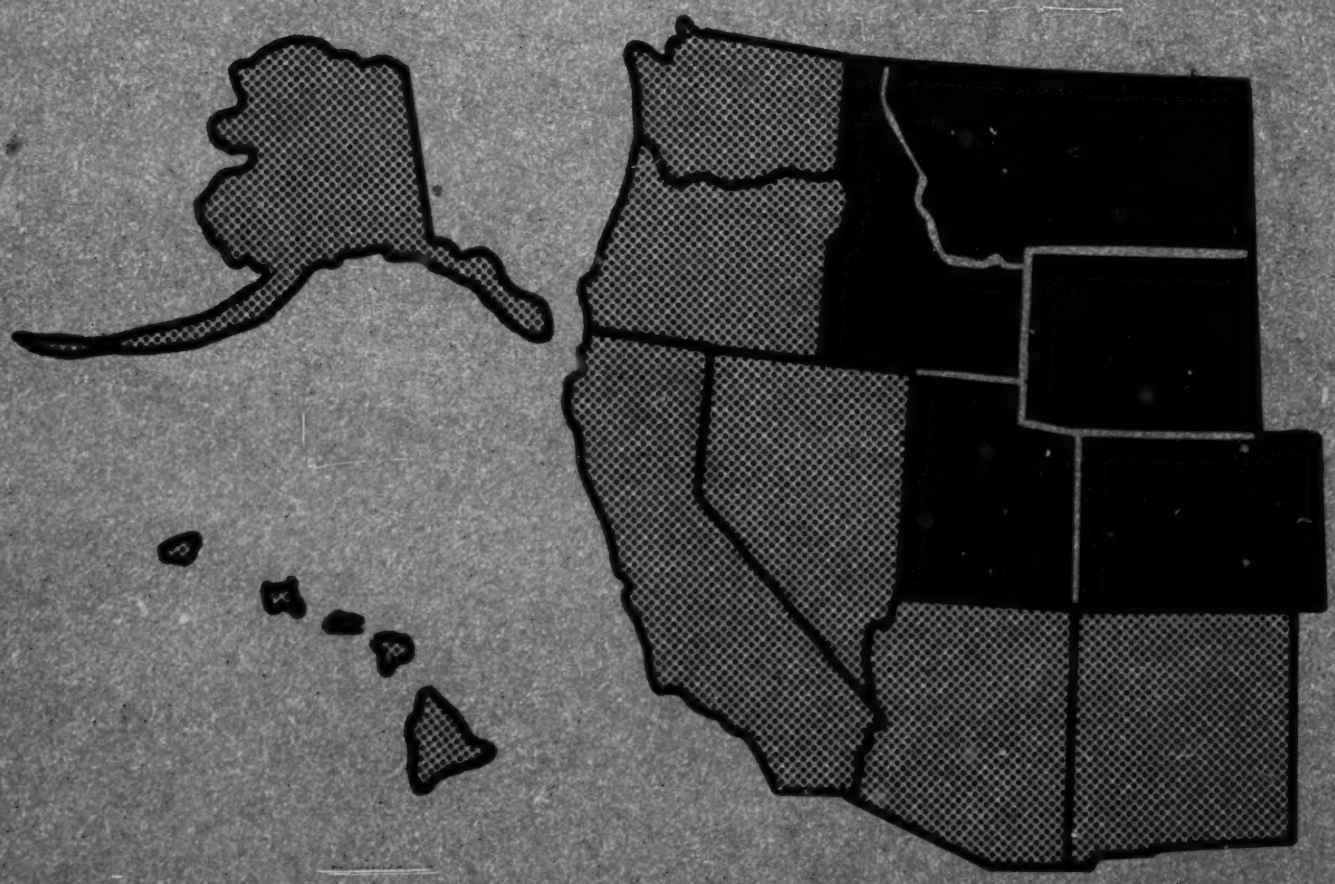
Disability and Deprivation



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DISABILITY AND DEPRIVATION

(Selected papers of a conference on disability and deprivation, June 9-10, 1969, in Boise, Idaho)

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

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Western Interstate Commission for Higher Education
P.O. Drawer P Boulder, Colorado 80302
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PREFACE

For almost a half a century those of us in rehabilitation of the handicapped have worked closely with disabled persons in our efforts to restore them to productive lives. We have undoubtedly learned much about disabling conditions and their effects upon the lives of people as well as about the services and aids that have proved helpful in overcoming handicaps.

In our preoccupation with the needs of the individual, however, it is doubtful if many of us have been more than dimly aware that there was a shocking correlation between the incidence of disability, mental or physical, and the socio-economic status of the people we served.

It was the chance reading of a book by Rodger Hurley, "Poverty and Mental Retardation--A Causal Relationship" which brought home to some of us the fact that in our efforts to develop better services to the individual we had blinded ourselves to the deeply rooted social and economic causes of much of the disability we view daily in the troubled people who come to our offices for help.

It was thus our hope that a short session of this nature, which would attempt to broaden the tunnel vision we had developed through the decades of looking only at individuals, might give us greater insight into the root causes of our client's problems and result in more effective services. We tried to bring together workers from several fields who must deal with the results of these social and economic factors, to expose them to the views and opinions of diverse authorities, and to give them time to meditate and discuss these views and opinions, some of which must have run counter to our comfortable stereotypes.

We picked the title of "Disability and Deprivation" as covering broadly the spectrum of problems our participants are trained to work with.

It is our hope that at the very least a few sights were lifted, a few horizons broadened, and possibly some of us might re-examine our traditional practices and attitudes which may have stood in the way of our well-intended efforts to solve the problems of the handicapped.

This institute was made possible by cooperative effort and funding involving the Western Interstate Commission for Higher Education, Colorado State College, and the Rehabilitation Services Administration.

Andrew Marrin
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Welfare

Regional Office
Denver, Colorado
August, 1969

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POVERTY AND MENTAL RETARDATION: A CAUSAL RELATIONSHIP

Rodger L. Hurley
New York, New York

There are three positions in the United States with respect to poverty and its effect on intellectual development. The first position represents about 95 percent of the population and is rather profound ignorance concerning the nature of poverty and its potential effect on children--its potential effect on intellectual development as well as physical development.

A very small percentage of people have what I would characterize as a cocktail party kind of knowledge of poverty in America; they have no contact with disadvantaged people. So they are not asking very hard questions.

The third category, which I think is the most important one, is composed of the very, very few people who have an understanding of poverty, the middle-class individual who learns through his association with disadvantaged people. He understands the problem to the extent that he attempts, in his daily activities, to use the levers that he has with individuals and institutions to change the situation.

Today, I want to give you my personal point of view in regard to the nature of poverty in the United States and also a thumbnail sketch--an overview--of the kind of damage that is taking place and why it's taking place.

I want to speak about mental retardation because this is the area in which I have done the most research. Mental retardation is relevant to the question of intellectual development in the United States, to investigation of how children fare in this nation--the children on the bottom of the socio-economic pole.

We know that at least 70 percent of the children in this society who are determined to be mentally retarded are disadvantaged. They come from lower socio-economic backgrounds. They are Black, they are Mexican-American, Spanish-speaking people; they are poor Whites. It's my conclusion, on the basis of my experience and my research, that there is no difference between these people and the millions of other children who are in the American ghettoes, who are in the disadvantaged areas of America. We're not talking about genetics. We're talking about the damage that is done to them by the society, and by the institutions which supposedly have been structured and designed to ameliorate the suffering.

So today I am going to structure my talk around an evaluation of institutions in America which have been designed to help disadvantaged people. These institutions are supposed to ameliorate the conditions of poverty, but too often they have no impact at all, and on frequent occasions, they actually augment suffering. I am going to take a very quick look at the public education system, welfare, health services to the poor, housing programs, and the food assistance programs.

Probably, in the discussion of mental retardation, the most important institution is public education. We know that the poor are not involved in the process of public education and are in fact turned off by it. They have no stake in it. They flunk out at unbelievable rates. But, even more importantly, a tremendous percentage of these kids wind up with certificates of attendance. They are not really modified high school graduates. Even when they do get high school diplomas, they can't read; they can't write; they can't function. They have been pushed through that system, and that's all there is to it.

The poor feel, and accurately so, that they have no influence over what takes place in the educational system. They have no control over it. Partly because of this, there is very little communication between people who run the system and the people who have to partake of the system,

between the parents of the disadvantaged and the professional educators. The urban public education system is a curious hybrid: we have a number of upper class groups running the board of education; we have a middle class group representing the teachers; and, in the ghetto districts, we have lower class children as students.

It should be no surprise that the poor are not represented on the school boards. School board positions are unpaid positions. More importantly, people who are on the school boards or have been on school boards have no interest whatsoever in bringing in disadvantaged people and hearing their point of view as regards what should happen in a classroom. In the past, the poor have been afraid of this aristocracy, of the school board. I do not think this is, in many instances, any longer true. The poor are not willing to allow professionals to run the lives of their children leaving them, as parents, without an opportunity to affect what happens. Stemming from this powerlessness, from this inability to control what happens in the classrooms, educational practices have been developed and remain today which in effect insure that the poor are not going to succeed in the public educational system.

On the basis of measures which are inaccurate and discriminatory, lower class children, frequently at the earliest stages, are placed in classes for "slow learners." I am talking about I.Q. tests, adaptive behavior measures, and other measures which do not reflect the kind of potential that disadvantaged children have.

Recently in Washington, D.C., the practice of tracking was declared unconstitutional, but it is still practiced throughout the nation. I would like to refer at this moment to a quotation by Kenneth Clark which I think states eloquently the consequences of this practice:

> Children themselves are not fooled by the various euphemisms educators use to disguise educational snobbery. From the earliest grades, a child knows when he has been assigned to a level that is considered less than adequate. Whether letters or

> dog or animal names are used to describe these groups, within days after these procedures are imposed the children know exactly what they mean. Those children who are relegated to the inferior groups suffer a sense of self-doubt and deep feelings of inferiority which stamp their entire attitude toward school and the learning process... they have a sense of personal humiliation and unworthiness.

One can only guess about the damage which is done when a child is told that he is mentally retarded. Nobody has ever taken a sample of the children to determine how they feel about being determined to be mentally retarded. Let me assure you that this has very pernicious effects on the attitude of the child toward himself and toward his peers. When a child is branded as mentally retarded, it is the end of the road.

Thousands of children are being placed unjustifiably in classes for the mentally retarded and educable mentally retarded. This is because of inadequate measures of what constitutes intelligence, but more importantly because of racial bias, because of socio-economic bias, because of a public school system which is under financed and under staffed and presently is breaking down.

I would say that 70 percent of all those children who go into classes for the educable mentally retarded ought to be someplace else; they ought to be in the normal education system. I would like to refer to a study that was recently completed in California. We know there is a rather significant population of Spanish-American people in this country. The researcher ran a sample group of 47 mentally retarded children who were Spanish-speaking. The children were given I.Q. tests in Spanish (a rather brilliant move on the part of the researcher). The test was structured to relate to the particular background of the child. The results of the test showed that 37 of the 47 children who were evaluated were no longer

considered to be educable mentally retarded. The situation for Spanish-speaking people is exactly the same as the situation we have for Black people in this country. They are not being evaluated accurately.

Another dimension of the weakness of poor people and the impact that this weakness has on the practices that exist in school is something that could be extremely simple and is overlooked. It is what I consider to be the cost of free public education. I'm not talking about the cost of buying new shoes, shirts, pants, and coats. Let's look at the child after he comes to school ragged and dirty and see what expenses he has to pick up so that he can go through the system. We know he looks ragged and dirty. We know he knows this. He perceives that he's ragged and dirty. We know it affects him and his attitudes toward his peers. It has a negative impact on his ability to perform in school.

But let's not worry about that for the moment. What about the cost of gym clothes, lockers, towels, pencils, pens, workbooks, handbooks, and the myriad of other costs that children are supposed to pay in our particular society if they are to play the role of students? We aren't mentioning extracurricular things such as yearbooks, class rings, prom money, whatever. Where does this money come from? It doesn't come from anywhere because these kids don't have it in the first place.

I refer to a study by Haubrich done in New York City:

> In the Hunter Project we did a survey of one eighth grade class for a three-month period as to "extra money" children are asked to bring to school. It amounted to $26.50. In this class 70 percent of the children were in families on the welfare roles of New York City. A family on welfare in junior high schools receives 25 cents a month extra for the child's extra expenses!

Let's go on to the textbooks which are provided for the poor, both Black and White children. We know that before World War II the texts used in the classroom were outright racist in many instances and were blatantly bigoted. Terms such as "Black Sambo" and others were used. This is no longer the case. I do not think that there are many of these texts left in this country. But now the majority of text books are almost to the same degree silent destroyers of the potential of disadvantaged children. The ones that I am talking about are used by the system now, not the ones that are discussed on the front page of the Time magazine section or New York Times magazine section, but the ones that the kids use on a daily basis.

In these, there are no poor people; there are no Black people; there are no slums. As Otto Kleinberg has noted: "Life is fun in a rich, happy, fair-skinned place." And the newest texts which have been brought into the system--the best texts--are also often fundamentally inadequate. There may be Black faces, but life is pictured as if it were the ideal suburban heaven. There is no poverty, no opportunity for the child to identify himself in the particular text, for him to locate himself so that he can understand what he's doing in this particular situation.

We know that many of the children in the ghetto, many children in the urban areas, never leave a 25-block-radius around their homes. I know this may be hard to believe, but there are many, many children in New York City who don't have the slightest idea of what an ocean is, what a big body of water is. They have a tough time with their names and with the most fundamental aspects of what we consider to be formal education.

What I am trying to say is that, if the textbooks don't provide some kind of measure of relationship to their environment, these children give a stiff arm to the textbooks. They have no interest in the books.

The most important factor in school and in education, without a doubt, is the quality of the teacher. To get right to the point, teachers in America have no interest in going to the ghetto. This is not the highest priority item on the block. Each year, some teachers who were forced to go to the ghetto because there were no other positions available, qualified teachers, leave the ghetto districts as soon as possible. They are replaced by substitutes who have provisional certificates, who are not "fully qualified teachers." They leave just as quickly as they can to go to another district.

The end result is that some classes have as many as 10 or 15 teachers per year. It is impossible in this situation for the teacher to develop rapport with children, and the children have no interest. They're just sitting there, biding their time.

We have allowed a teacher corps to develop in the United States which is more in opposition to the interests of disadvantaged children than it is in harmony with them. We know without question, because teachers are the reflection of the kind of society that we have, that there are teachers who are plainly bigoted. Hopefully, that's a small number. There is a much greater number, I think, who are fearful and angry and frustrated because of the nature of children that come into their classes. They feel the need to strike out at these children, to dominate them, and to force them into a middle class role. The children perceive this. They have no intention of going along. Rather than having an educational or learning process going on in the classroom, we have a little bit of a guerilla warfare, with the teacher trying to knuckle down the children and the children trying to outwit the teacher.

Even if the two categories that I mentioned do not honestly represent the attitudes of the majority of the teachers in the United States, I think there is a larger group with another characteristic. In some instances, I think it is well meaning, but the damage is nevertheless done. The teachers are convinced that their charges have been so

extensively damaged by the culture of poverty that there is no hope for them, that they can't function, that they can't learn, and that there is no point in making a personal investment because the investment is not going to bear a significant return. As George Jones has said:

> These disadvantaged students are relegated to the arena of the untouchable, unteachable, undesirable--where nothing is expected of them. Teachers treat them as if they are nothing, have nothing, including brains, and will amount to nothing. Hence, they end up with nothing, having never really had a chance.

I believe this attitude and its effect, which is called the self-fulfilling prophecy, is a virulent infection in this nation which can be seen, can be identified, in just about any part of the country.

I would like to fully delineate the impact of teacher attitudes toward disadvantaged children by referring to a recent study which was done by Robert Rosenthal in San Francisco, California, with Spanish-speaking children. I think it's probably the most important piece of educational research which has been done in the last decade--maybe even a greater period of time. He went into a San Francisco school and told the teachers that there were a number of children who had been identified as spurters ahead. That is, on the basis of measures that supposedly had been used with these children prior to the time he spoke with the teachers, these were really bright children, and they were going to spurt ahead shortly.

In fact, they were no different from the other group of children in the classroom. They were picked out from the school on a random-sample basis. At the end of three years there was, in some instances, a differential between the control group and the experimental group of something like 27.5 I.Q. points, a very, very significant difference in the I.Q. advance of the children who were in the favored group as opposed to the controlled.

Teachers have a tremendous influence over the development of their charges, especially children of the ghetto who have not learned middle class ways of coping. If the teacher thinks that the child is a punk, that he doesn't have the stuff, the child is going to act as if he's slow. The negative attitude of the teacher will damage the child's identification of himself and markedly retard his performance in class. Conversely, if the teacher believes in a child and if the teacher expects the child to perform, in a great many instances this happens. The child does perform. I think this is exactly what the militant Black population of this country recognizes. Teachers who are in our public education system are not geniuses to start off with, but what is worse, they do not have faith in their charges, they do not believe these children have the stuff to make it.

What we need are people, especially Black people, to come into the classroom because they believe that the children can learn. If this is the case, the children will function considerably better than they are right now.

If the factors that I mentioned already do not guarantee that the poor child will be put away with the mentally retarded, I would like to look at one final aspect of the public education system in America. Every major study that has been done on educational facilities notes that, in terms of study space, cafeterias, laboratories for science and language, libraries, adequate number of classrooms, recreation space, everything mentioned that you can dream of in regard to facilities, the poor get the least, and they get the worst.

As I suggested at the beginning of this talk, the failure of disadvantaged children of our society is unfortunately not solely the function or the failure of the public education system. There are other institutions involved in this downward process. I would like to continue from here and give you just a thumbnail sketch of my thoughts in regard to the quality of these systems.

The first of these other systems is welfare, which is, as Whitney Young has stated, "an obsolete, punitive, ineffective, inefficient, bankrupt system which perpetuates the very social ills it was designed to combat." It has been attacked by politicians from the left, right, and center, those who are below, and those who are above. Because of inhuman regulations that attend it, welfare often breaks up families rather than helping them stay together. Nor does it provide a mother and children with resources that even the federal government acknowledges as necessary for a decent existence.

It has been and continues to be used capriciously and arbitrarily to keep families from getting what is theirs by law or from involving themselves in political action to change the government and the nature of things at the local level. Welfare, throughout the nation, is a fundamentally corrupt system. It's only intelligible goals are to exclude people from assistance, to give as little as possible to those who need it, and to give what is given in a demeaning and undignified way. If we ever were to make a cost analysis of the welfare system, it would have to be the most inefficient system that man has ever designed on this earth.

Health services for the poor are also inadequate and, consequently, are not doing the job for which they were designed. I would like to open my comments on health services by quoting Dr. Jack Geiger, the outstanding director of the Columbia Point Medical Center in Massachusetts, and also director of the Mound Bayou Community Health Center in Mississippi. As Dr. Geiger has accurately commented:

> Many of our nation's health services for the poor are divided from them by barriers--barriers of time, distance, inadequate transportation, loss of a day's pay, lack of a baby sitter, complex eligibility requirements, impersonality, fragment of service, and a stigma of charity.

What I am talking about was beautifully exemplified, and may still be the case, by health services for the people in Watts where it's required that they get on a bus for an hour and a half to get to the health center, then wait all day to have their child looked at if they're lucky. I suppose on the national basis poor people can get slashed on the arms, have broken legs, and have them attended to. This is not the case in some instances in New York City right now where there has been a cutback on the allocations of resources to the hospitals so we even have M.D.'s, who are not the most leftist group in this society, screaming that patients are dying because they don't have enough operating rooms to take care of these people.

For millions of poor people as well as for lower class and middle class people, preventative health care, however, is nonexistent. It is a figment in the minds of those who give talks about health services for the disadvantaged. We talk about millions of people who are poor in this society. Right now there are 36 community health centers in the United States. This lack of service allows damage to take place which directly and indirectly contributes to distorted, unhealthy intellectual and physical development. It contributes to the situation where, in all the studies I've seen, the disadvantaged have a greater incidence of mental illness and have more intense mental illness, more neuroses, more phycoses, more clinical diseases, infectious diseases. Just about every one that you could possibly mention, the disadvantaged have more of.

The most recent survey, 1967, for the Communicable Disease Center in Atlanta for the White population shows that 16.6 per 100,000 people contracted T.B., and in the Black population 70.2 per 100,000 people contracted T.B. In Newark, New Jersey, which I offer as a classical representation of what urban poverty is all about, the rate has gone over 100 per 100,000 people.

Eunice Shriver has delineated another major example of the puniness of the health services for the poor. She has stated, "Poor pregnant

women in America receive less care than do pregnant cows." The result of this lack of attention, as any intelligent human being would perceive, is damage and death. Our infant mortality rate, a good index of community health, is the 18th highest in the world. That is, 17 other nations have a lower rate of infant death than does our society. Our rate is over twice as high as Sweden, and the rate of New Jersey is over three times as high as Sweden. At this particular time, our government, which is a reflection of each of us, proposes that we should cut $6 million out of the budget for health care.

Another category which I would like to discuss briefly is housing. Relative to the number of men, women, and children in this society, 25 million or so, who have been determined to be impoverished, who have been determined to be living in unhealthy dwellings, the number of housing starts per year are minuscule. The poor are living in shacks, in tenements in the urban areas. They're fantastically hot in the summer. I don't see how a child could possibly concentrate on anything. I don't see how he could function in any normal way.

When it gets 99° in New York City, the children swarm out of the buildings; they just come out like a wave onto the street. It's impossible to drive down the street in New York City without getting speared by the water from a fire hydrant. You don't stop. You keep on moving because nobody knows what's going to take place. You know there is a confrontation right around the door, and you just keep on going if you want to survive. I live on 73rd Street on the west side of New York City, and I don't know if any of you people have been close by, but I assure you this is the case.

Beyond the fact that these children live in environments where they can't possbily function in a normal fashion the way your children or my children are functioning, there is a tremendous amount of overt, physical damage done to these children in the ghetto in America. For example, it is conservatively estimated by scientists that there are over 225,000 young children who are presently suffering from the "silent

epidemic" of lead poisoning. The dimensions of this damage are unbelievable--225,000 is a conservative estimate. These children are ingesting the flakes of plaster that crumble off their walls, and because of the lead based paint which was used a number of years ago, the children get lead poisoning.

And one final category, food assistance programs: I think the food assistance programs represent the perfect example of the American tragedy. After three years of congressional hearings, it is agreed that there are millions of Americans in society who are suffering from hunger and malnutrition. But the existing food programs are misnamed: they were never designed to feed the hungry. They were passed by southerners, southern congressmen to maintain farm prices, and they are administered by the Department of Agriculture. So we have a situation where neither the food stamp program, nor the commodity distribution program, provides even an adequate minimum diet by the standards of the Department of Agriculture itself.

Beyond this, however, despite flaws which exist in both the commodity distribution program and the food stamp program, only 6 million people are reached under both programs. At least 15 million people that the government has classified as poverty striken cannot receive any food assistance at all. At the same time, 4 million disadvantaged children go to school and do not benefit from the hot lunch under the National School Hot Lunch Program while almost 10 million middle class children do. What is the response of us--of our society--of our government, to hunger and malnutrition? It must wait until 1973 to feed hungry children!

While we have a gross national product of over $9 hundred billion, a proposed federal budget of $190 billion, while several corporate farms last year received over $3 million not to produce, while 16,000 farmers received an excess of $20,000 not to produce, while senators, congressmen, supreme court justices get their $20,000 extra per year for salaries,

while we spend $24 billion to throw a man to the moon, we can't find $2 billion to feed the disadvantaged in this country. This lack is a reflection of us, of our society, and the whole issue of rehabilitation in this society.

We never can get any real return on rehabilitation unless we prevent a great deal of what's happening. We keep on talking to one another. We're both convinced, but nobody else is convinced. What we need is a lobby, a lobby of poor people, a lobby of people at the institutions you represent to compete with the oil lobby, the automobile lobby, the military industrial complex, the agricultural lobby. There are hundreds of them. We need a lobby to put the development of children on the upper rank of priorities, right up there with the military industrial complex and the others. In San Francisco, two sets of crews working on a submarine inadvertently sank the submarine at its moorings! $25 million went out the window. In Denver, Colorado, they have thousands of disadvantaged children who are not doing well in school. I don't see anybody running down to Denver, Colorado, to make a $25 million investment in children. Yet I think children should receive at least the same priority as submarines.

There is a tremendous resistance in this society to change. Much of it comes from the people who inhabit the institutions such as welfare, vocational rehabilitation and Community Chest, that you represent today. Over a period of time there are many who have become more wedded to their institutions than to those whom they were supposed to be working with to help.

A change is coming however. It's going to come, or we are going to split apart. Our's is an urban society. The majority of our people are in urban areas and that is where the real strain is. I'm not in any way underestimating the damage done in rural areas, but the tension, the political gasoline tank, is in the urban areas. Either we are going

to change or we are going to rupture. In fact, we are rupturing. In New York City, for example, the social and political structure is breaking down. It may not be a relevant experience in this part of the country, but I think it's relevant to an understanding of what's happening in urban areas.

We can see in other parts of the country that people are not willing to pay for a raise in the investment they are going to have to make in schools. I would say today that either we are going to have a renaissance, or we are going to stop. I hope we can take the responsibility to play a role in the changes which ought to take place. I think we can see that role more clearly by attempting to look at the world through the eyes of the disadvantaged.

We have to develop a new kind of faith in the poor children, to believe that they can function, and to demand that they function.

There must be a new candor on the part of the people who represent institutions in our society. There is a certain expertise that society believes that we have. In the past, our language has been loaded with jargon, it has been irrelevant, it has been inaccurate. We are going to have to speak out honestly. We're going to have to speak up clearly.

We have the resources in this society to end poverty--to end the human destruction which daily takes place. We have unparalleled resources, but we lack the will to use them for human goals. Mental retardation in America is just one end product of poverty; if our nation is to abide by its philosophy and its rhetoric, we must begin now to eradicate this poverty. Society is no longer justified in shunting aside large numbers of disadvantaged children into classes for the educable mentally retarded--into separate and unequal facilities. In the midst of plenty, we can no longer hide our callousness and avoid our individual and national responsibilities.

HEALTH PROBLEMS--HEALTH CARE

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Denver Department of Health and Hospitals
Denver, Colorado

One of the most popular discussion topics for out-of-town dignitaries is the "health status of the poor." This subject is exceedingly popular because the speaker as well as the audience has the opportunity to express concern for the status of our society. If the speech is good, everyone leaves the amphitheatre feeling he has "REALLY BECOME INVOLVED." Discussing the health status of the poor has reached the point where it is almost like discussing adultery: A great deal of vicarious pleasure can be experienced by condemning society, grinding your teeth, and feeling exceedingly self-righteous about yourself, knowing it would not have been permitted had you been in a position of authority.

FACTORS INVOLVED

In reality the health status of the poor is poorly understood. Many statistics are available. Some of them are valid; some are subject to question. But the causation, valid or invalid, of these statistics is relatively unknown. All we can say is that the level of health of the poor and the delivery of health care to the urban and rural poor are very real problems of our society. They are much larger problems, I am sure, than most of us realize. I feel this problem is associated with, but not entirely dependent upon, the following factors:

1. IGNORANCE

   In Denver we have found that large segments of our society do not recognize the value of early diagnosis

and treatment of diseases nor the value of preventive health measures much less the value of establishing an on-going relationship with a physician or health facility. To be honest, the value of preventive health measures is not really understood by any segment of society.

2. HOSTILITY TO THE ESTABLISHMENT

This factor is, on occasion, a very real impediment to the health care of individuals and families. The basis of this hostility need not be the frequently discussed "race relation" problem. Simple observation of some of the traditional methods of health care delivery in the private physician's office, the pharmacy, and the clinic, not to mention the city hospital, shows an ample basis for this hostility.

3. CULTURAL SHOCK

Cultural shock has been recognized by epidemiologists as a basis for severe health problems. Mountain native populations of Vietnam and other areas, when moved to urban areas, have experienced marked increases in mortality and morbidity from diverse diseases.

This has not been adequately studied in our agrarian Negro and Mexican-American population as they make the transition to urban life. The increase in ulcers, hypertension, etc., that has been noted in newly arrived urban families is suggestive, but not conclusive. I feel this possible cause of the noted increase of disease in this population is worthy of investigation.

4. GENERAL AND SPECIFIC SUSCEPTIBILITY

Certain general and some specific patterns of increased susceptibility have been noted. The increased susceptibility observed in persons suffering from nutritional inadequacies

has been brought before the national conscience through the efforts of Senator McGovern and others. Certainly, crowding and inadequate sanitation are recognized as factors that increase incidence and susceptibility to some diseases.

The specific entity, sickle cell anemia, and its related problems are almost exclusively problems of the Negro in our society. There certainly may be other forms of susceptibility which have not yet been clearly or properly defined. As medical scientists, we must carefully examine these possibilities. We must neither be "oversensitized" nor afraid to look for these factors.

It is impossible within the scope of this paper to define the full scope of this health problem. A brief overview of some recent data, however, is worthwhile.

One of the more commonly used indices of the health status of a population is the comparison of the experiences of subgroups with regard to vaccinations and immunizations. Comparisons of this type can afford an estimate of the quality and quantity of available health care. The U. S. Department of Health, Education, and Welfare statistics, reported in the United States Immunization Survey - 1967, 1968 (see Table I), indicate the level of oral polio vaccinations in the population residing in the core city and the suburban residents of major metropolitan areas. A highly significant similarity to this experience has also been observed with the DPT immunization program between white and nonwhite residents in our major metropolitan areas as is noted in Table II. Certainly these two factors do not give a comprehensive view of this situation. They do demonstrate, however, that a difference definitely exists.

A frequently used measure of community health is mortality. I am sure we all agree that mortality is the absence of health. Crude

TABLE I

IMMUNIZATIONS
UNITED STATES 1968

ORAL POLIO VACCINE
PERCENT RECEIVING 3 OPV
(Ages 1-19)

LOCALE OF POPULATION	PERCENT OF VACCINATED POPULATION
Core City	25.0
Suburbia	34.1

TABLE II

IMMUNIZATIONS
UNITED STATES 1968

DIPHTHERIA-PERTUSSIS-TETANUS
(Ages 1-13)

AGE	PERCENT WITH 4		PERCENT WITH 0	
	White	Nonwhite	White	Nonwhite
1-4	36.3	23.6	6.9	17.0
5-9	65.6	42.7	3.2	8.7
10-13	71.4	46.6	3.1	8.8

mortality rates, however, certainly leave much to be desired. Table III demonstrates the well-known fact that poverty areas in a community have a significant, excess mortality rate. I have chosen to list only four factors. These causes of death, I feel, should be imminently preventable.

Inadequate nutrition--a cause of human suffering in and by itself--is recognized by all as a factor in increased mortality and morbidity from disease. Dr. Arnold E. Shaefer recently discussed the nutritional status in Texas. The study, presented before the Senate Select Committee on Nutrition and Related Human Needs, reveals significant undernutrition in the lower fourth of the census tracts in Texas (see Table IV). People living in these tracts have significantly less than acceptable levels of vitamins, plasma proteins, and hemoglobin.

Both Tables V and VI indicate, as we should expect, that the most severely affected individuals in this population are the very young. The long-term effects on general mortality and morbidity of this deprivation during the growing years have not yet been adequately evaluated.

Another very concrete area directly related to community health is the availability of medical care. Table VII indicates the variation in office visits to physicians per year according to income. Our Denver experience strongly supports these statistics. Prior to the advent of the Neighborhood Health Center, only 12 physicians were located in the census tracts, which have become target areas of Denver's program. The population served is in excess of 90,000 people. The remainder of the Metropolitan Denver population, which totals approximately one million people, are served by over 1,000 physicians.

Although incomplete, the foregoing statistics demonstrate that a health care problem associated with the urban poor does exist. A reasonable question might be asked: What can be done about the problem? The most often heard solution--one that is typically American--is "Let's spend a bit more money." I seriously doubt whether this is what is

TABLE III

DEATH RATE

NEW YORK CITY 1961-63

	POVERTY AREAS	NONPOVERTY AREAS	EXCESS %
FETAL MORTALITY	34.8	21.8	60
MATERNAL MORTALITY	11.8	5.0	136
TUBERCULOSIS	15.3	6.9	121
PNEUMONIA	53.5	41.0	30

TABLE IV

LABORATORY FINDINGS

PERCENT OF POPULATION WITH LESS THAN ACCEPTABLE LEVELS
(All Age Groups)

VITAMIN A	13.0%
VITAMIN C	16.0%
HEMOGLOBIN	15.0%
PLASMA PROTEIN	16.0%
SERUM ALBUMIN	17.0%
URINARY RIBOFLAVIN	19.0%
THIAMIN	9.0%

TABLE V

SERUM VITAMIN A LEVELS

PERCENT OF POPULATION WITH LESS THAN ACCEPTABLE LEVELS

AGE	PERCENTAGE
0-5	33.0%
6-9	29.0%
10-15	18.0%
16-59	8.6%
60+	3.8%

TABLE VI

HEMOGLOBIN LEVELS

PERCENT OF POPULATION WITH LESS THAN ACCEPTABLE LEVELS

AGE	PERCENTAGE
0-5	34.0%
6-9	15.0%
10-15	12.0%
16-59	8.8%
60+	8.1%

TABLE VII

PHYSICIAN COVERAGE

INCOME UNDER $3,000. = 3.2 Office Visits Per Year

INCOME OVER $10,000. = 5.0 Office Visits Per Year

AVERAGE = 4.5 Office Visits Per Year

actually needed. The United States is already spending more money on a percentage and actual cost basis for medical care than any other country. Yet, as you know, our standards of health care do not meet those of most European countries.

Another often heard solution is medical research. It goes without saying that most medical research in the United States is not directed toward the major preventable causes of this health problem. I strongly believe, however, that research into health care delivery systems and the redistribution of funds now being spent on health care are very badly needed.

NEIGHBORHOOD HEALTH PROGRAMS

The Denver Department of Health and Hospitals is one of the organizations which is researching and experimenting with new delivery methods. In 1964, before the passage of the Office of Economic Opportunity legislation, Denver had the foresight to begin planning a health care delivery program for the urban poor. As you know, Denver was the first city to receive a grant from the OEO for a Neighborhood Health Center. This grant, slightly in excess of $800,000, was to fund a facility programmed for an anticipated patient-load of 450 persons per week. During the first week 500 patients were seen. This facility now is processing approximately 9,000 patient visits per month.

Additional funds were obtained from the OEO Children's Bureau for Maternal and Infant Care Projects and for care of youth between the ages of 1-19 (Denver's Project Child), and from the National Institute of Mental Health for community mental health centers as well as other state, local, and private sources. These funds permitted expansion to two health centers and seven, soon to be nine, health stations. The neighborhood portion of Denver's health program now has an annual budget in excess of $7.5 million per year, an enrollment of 60,000 patients, and anticipates more than 250,000 patient visits during 1969. The Denver General Hospital is seeing an additional

250,000 patients in the Outpatient Department, hospitalizing 12,000 persons per year, and evolving from a traditional city hospital to a key part of the program.

We feel this movement of health care into the neighborhood has been of great value. We also feel that early, but suggestive, statistics are demonstrating the effectiveness of the Neighborhood Health Centers on the health status of Denver's urban poor. The efficient use of scarce health professionals as well as the already demonstrated acceptability to the neighborhood residents has been an expected and valuable fringe benefit.

Another experimental aspect of the Neighborhood Health Program is the initiation of new health professional vocations. The Nurse Practitioner, a new health profession created by Dr. Henry Silver of the University of Colorado School of Medicine to alleviate the problems caused by the shortage of physicians, has been discussed in other papers and presentations. Needless to say, the experimental laboratory for the implementation of this program has been the Neighborhood Health Center. Although I am not suggesting that this endeavor is the total solution nor that it has been totally successful, I do feel it is an enlightened approach to this pressing situation.

The Denver Department of Health and Hospitals has also implemented an extensive training program for neighborhood residents in the sub-professional field, ranging from neighborhood workers to typists, laboratory technicians, and PBX operators, to mention just a few. Through this program vital positions in the health centers have been filled, and the centers have become part of the community. Many of these trainees now are regular employees under the Career Service Authority (personnel agency for the City and County of Denver) and many other government and private agencies. The link these residents have provided to the community deserves strong emphasis. We could not function effectively without it.

In addition to our training and employment activities in the community, we strongly support the concept of resident participation at all levels of our health system. By this, we mean the very important and real capability of affecting the system. Table VIII represents the various levels where community representation is expressed.

The Denver Department of Health and Hospitals operates its Neighborhood Health Program from some 31 facilities throughout Denver. To make this system work, a combination of unit management and the more traditional line-authority administrative structure has been developed.

Table IX demonstrates the professional lines of authority to the patient. Table X demonstrates the administrative lines of authority and responsibility.

Table XI demonstrates the subspecialty service organizational scheme which is superimposed upon this administrative and professional management program. This mechanism assures the professional competence of physicians in each and every care center, postgraduate and undergraduate medical education, and direct patient admission to all hospital services.

Table XII shows a sample staffing pattern of a Neighborhood Health Center with the special responsibilities of each person of the overlapping areas of responsibility.

The complicated, but working, Organization Chart of the Agency applying these concepts is noted in Table XIII. The advantages of this administrative setup are several. The neighborhood patients have an administrative structure that, by design and commitment, must be responsive to their needs. Each facility is allowed to adjust to the characteristics of its particular patient population. Persons in positions of responsibility are able to hold particular individuals responsible for area problems--individuals who are knowledgeable and involved in that particular area.

TABLE VIII

COMMUNITY REPRESENTATION
DENVER HEALTH PROGRAMS

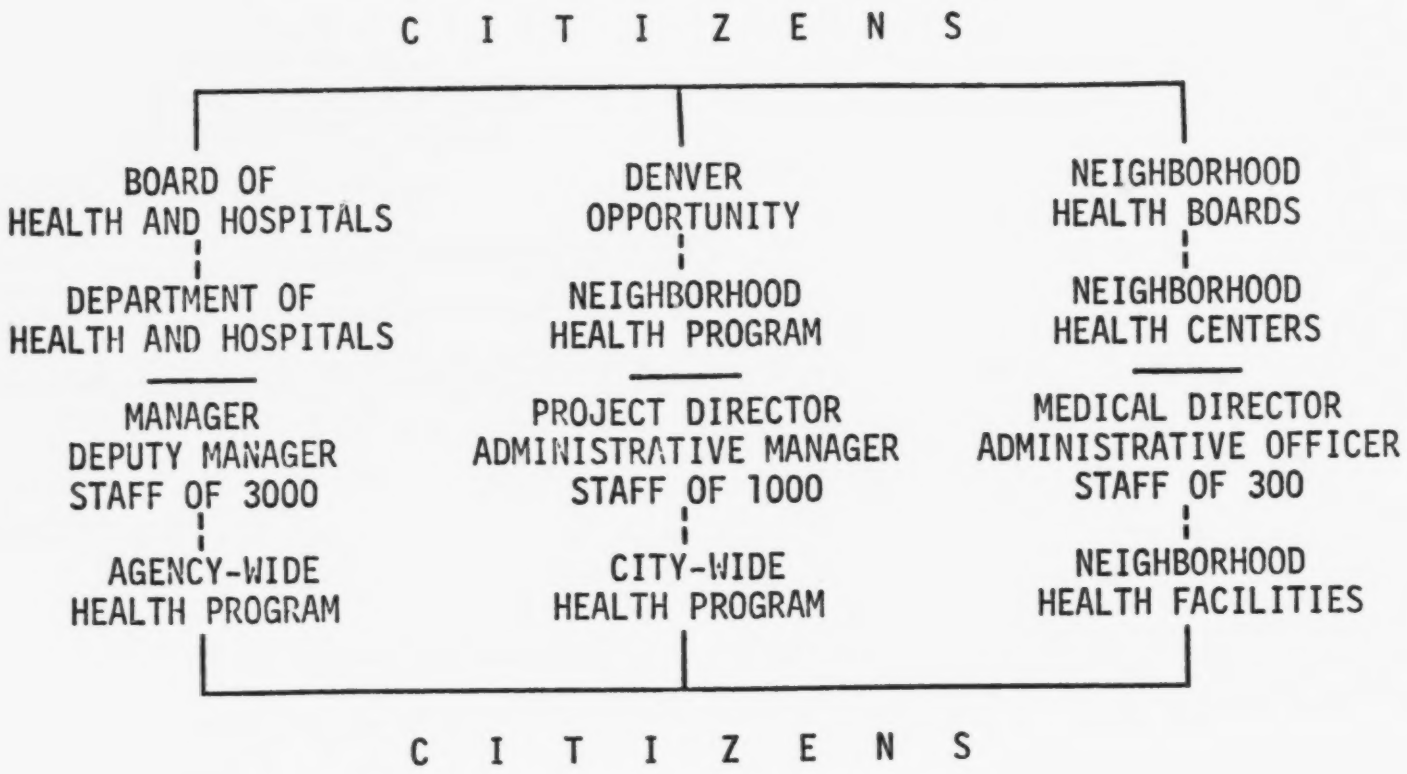


TABLE IX

LINES OF PROFESSIONAL AUTHORITY
NEIGHBORHOOD HEALTH PROGRAM

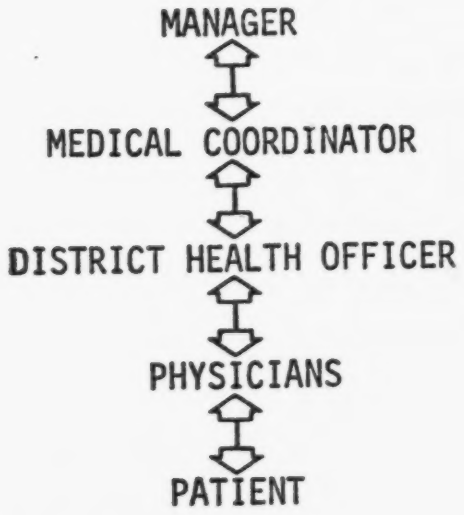


TABLE X

LINES OF ADMINISTRATIVE AUTHORITY
NEIGHBORHOOD HEALTH PROGRAM

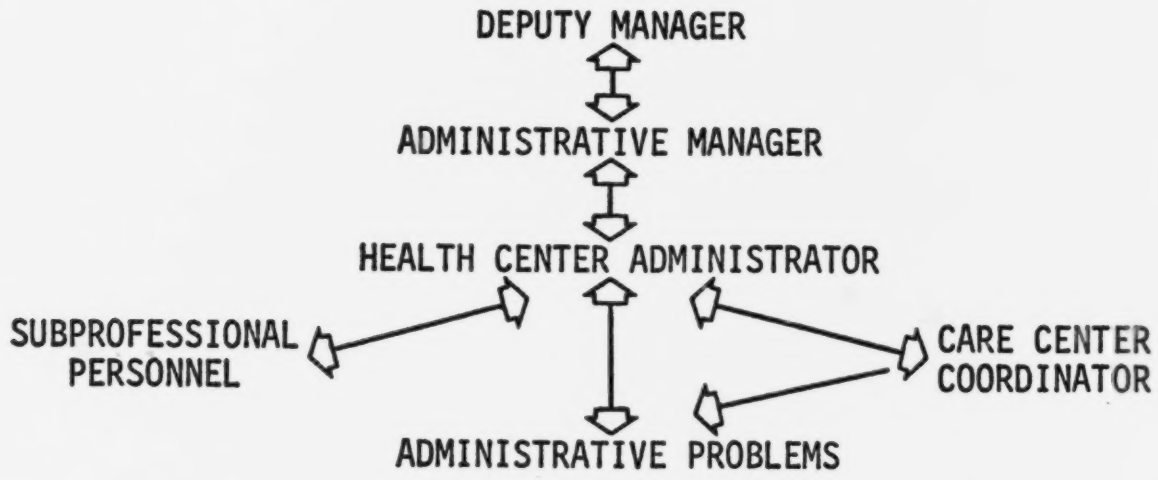


TABLE XI

SPECIALTY MEDICAL CARE
DEPARTMENT OF HEALTH AND HOSPITALS

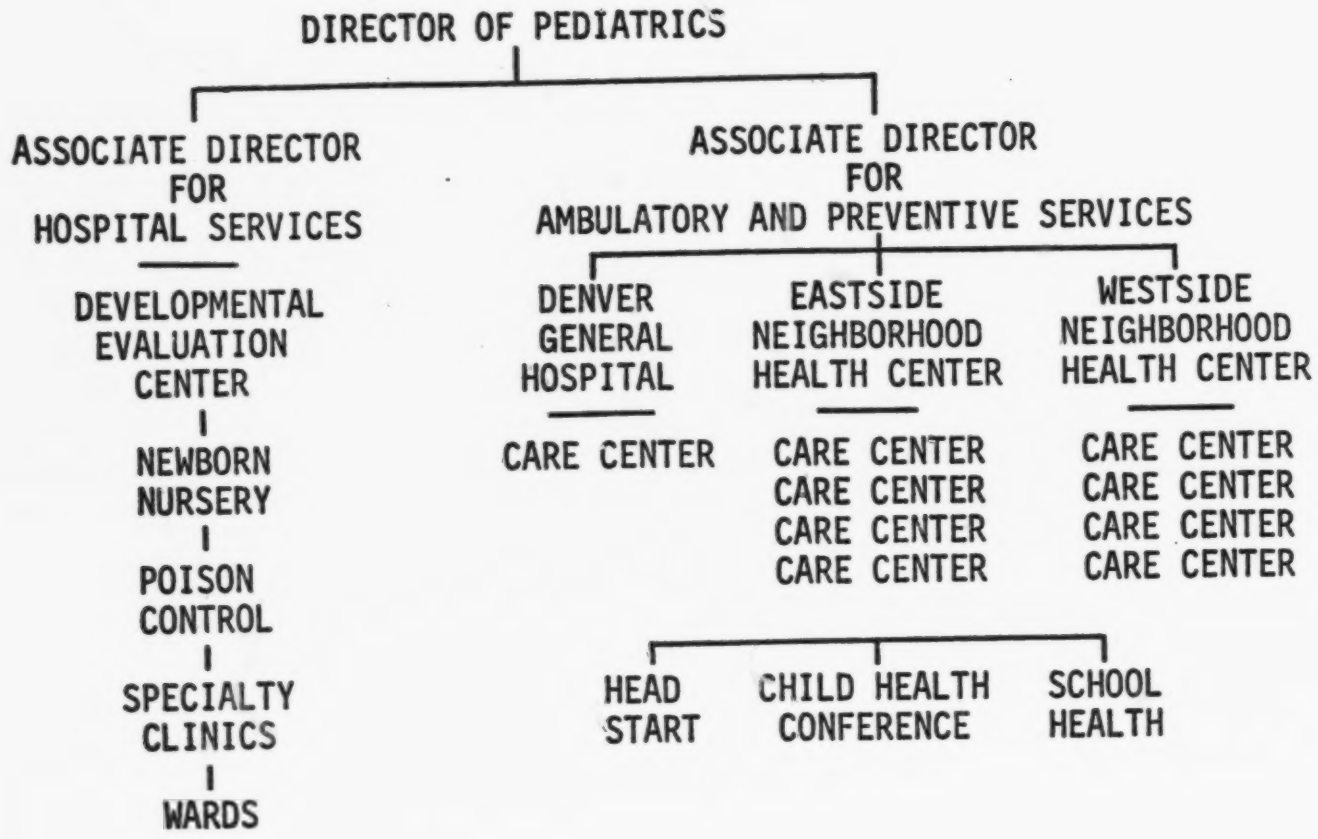


TABLE XII

STAFFING PATTERN
NEIGHBORHOOD HEALTH CENTER

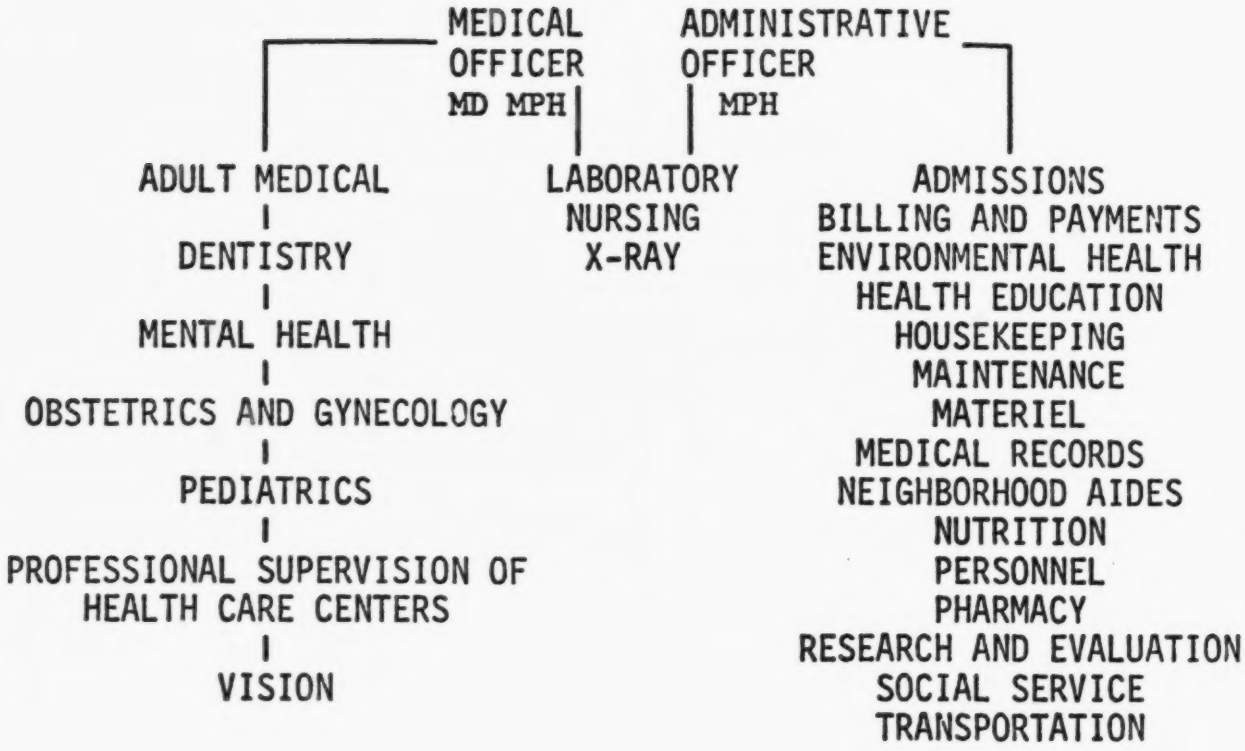
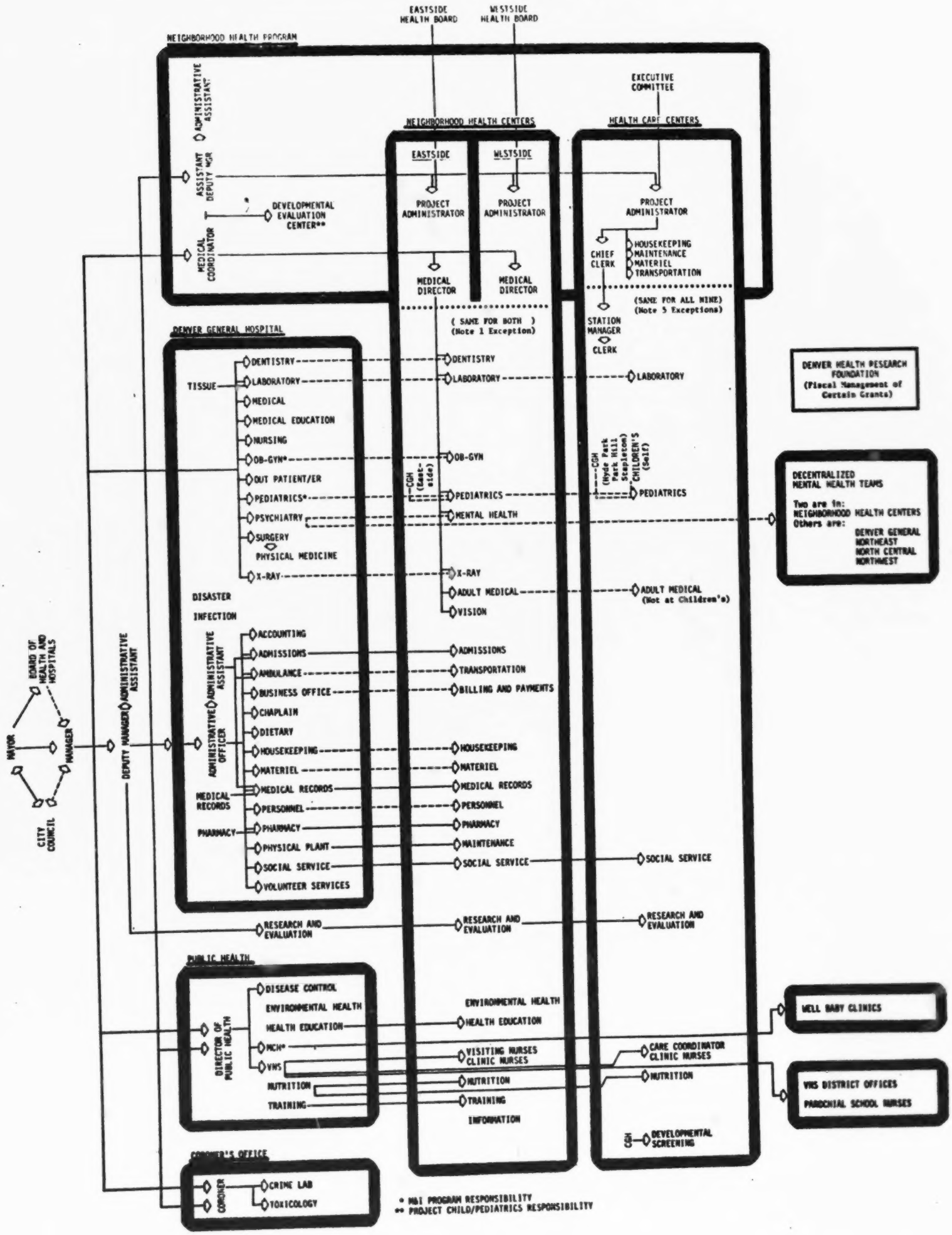


Table XIII

ORGANIZATIONAL CHART
DEPARTMENT OF HEALTH AND HOSPITALS



Health professionals have a close association with a major teaching institution for their continuing education and professional development. The health professional is provided with consultation with the most sophisticated diagnostic and therapeutic techniques available. As a result he may render the most sophisticated patient services available in the community; yet, this service can be rendered in a concerned, personal, and available manner.

This mechanism also provides the framework for the efficient use of expensive facilities, scarce or infrequently used professional skills, and for quantity-quality purchasing. The last, but not the least, important advantage is that this program implements the concept of maximum, feasible participation for the most important person in the system--the patient.

The department is also in the process of researching the possibilities of automation in improving and expanding the delivery of health care service. This includes not only the multiphasic health programs, of which I am sure you have heard a great deal, but also the very mundane problems such as medical records, and patient appointments which frequently block the effective provision of patient care.

Many other concepts are being developed, implemented, and modified in an effort to develop systems and mechanisms that have applicability in Denver and in other cities.

In summary we have reviewed the health status of the urban poor and noted various levels of experimentation which offer some promise of resolving this pressing problem.

LIMITATIONS IN SPECIAL EDUCATION SYSTEMS

Dr. John W. Kidd
Assistant Superintendent
Department for the Mentally Retarded
Special School District of St. Louis County, Missouri

It falls to me to speak to you of limitations in the system of which I am a part, special education, education of the exceptional, and specifically, for this institute--education of the handicapped.

I have chosen to treat our limitations as attitudinal, linguistic, scientific, and financial. I will try to point the way to the removal of the limitations as we encounter them here today. I have heard so much in recent years advocating change by destroying and/or abandoning current practice that I hope to exemplify what I have asked some of my colleagues to do, namely, to include a constructive suggestion with each destructive one--the advocacy of change on a "from-to" basis, pointing to what we need as well as to what we need to abandon, pointing to directions of change implied by goals and evidence rather than just giving voice to our discontent.

Someone has said that it is time to abandon our remedial model in special education. I say, "Fine--but for what model?" No answer!

Someone has said that it is time to abandon all our terminology and classifications of the handicapped. I say, "Fine--but only when something more promising emerges." Only with words--classifications--categories can we communicate about the disabled and only with such labels can we legislate and appropriate particularly for them. Someone says, "We don't need special legislation and special appropriations for the handicapped. Education will take care of all children and youth based on their individual needs."

Would history justify that position? The Vocational Education Act was amended to specify that 10 percent of the funds go to the

handicapped. Title I of ESEA was amended by P.L. 89-313 so that handicapped in state schools received aid; it was amended by Title VI so the handicapped generally would receive aid; and Title III of ESEA was amended so that 15 percent of its funds would go to the handicapped.

THE NEED FOR CHANGE IN ATTITUDES

This fact we must face. The typical educator is unaware of or insensitive to the needs and particularly the potential of the handicapped. He is likely to give proportionately less attention to their needs unless legally mandated to do otherwise.

As Dr. James Gallagher, associate commissioner of education in charge of the Bureau of Education for the Handicapped, U.S.O.E., recently pointed out:

> Our unspoken, but powerful educational philosophy seems to be the greatest good for the greatest number! This concept is good--unless you are part of the lesser number. That is where the handicapped are.
>
> Unfortunately, many regular school administrators do not have a background of personal experience with handicapped children, neither do they have any academic contact with the handicapped area. They invariably underestimate the abilities of a handicapped child in a positive environment and view special education expenditures as charity more than opportunity.
>
> I frequently carry around with me this very bulky document called the Budget of the United States of America. I have to admit it is not beautiful prose--it will never win a Pulitzer prize. What it is, however, is a fingerprint of our society. It tells of our intended deeds and it says more about us as a society than all of our rhetoric.
>
> Too often in the past, educators have operated as if they believe their programs' virtues were self evident.

> They believed that, if they would be good, "Papa" would be generous and give us a piece of candy, whether that Papa be a school board, or a superintendent, or a federal government. This is the ultimate in the dependency reaction. I think it is quite clear that resources will accrue to education not alone on the basis of any manifest value but upon a greater understanding by educators, and those who value education, of how political decisions are made. How are allocations of all these limited resources determined; whether at the community, or the state, or the federal level?
>
> Those who retreat into the comfort of "We can't do anything about the system," need to be reminded of the parent groups and their legislative accomplishments.

And I might add, need to be reminded of the fine persuasion brought to bear on the federal Congress over the years by Vocational Rehabilitation personnel.

I will not recite literature bearing out the well-known posture of the man on the street toward the handicapped in America. Too often it is a posture of intolerance, of derogation, and of rejection. The physically handicapped, the blind, the mentally retarded, and their several associated types of disabled are held in low esteem if not fear by many of our citizens. Great work has been done by many individuals and organizations to bring about a greater public understanding of the handicapped, of their needs, and of their potentials but much, much more must be done.

So much for attitudes--it is not the people who are here about whom I am concerned when I expressed the need for massive change in attitude in the American society. Yours are the attitudes to which all Americans might well aspire.

THE NEED FOR BETTER TERMINOLOGY

I now turn to the second of my designated limitations, that of linguistics. Our terminology is confused, inconsistent, and unclear. Dr. Cruickshank reported that more than 40 terms have been used to refer to the child which he calls brain-injured.

The mentally retarded in one state are the mentally handicapped in another state and even the slow learners in one of the 50 states.

In recent years legislation and programs have been emerging for children with learning disabilities. However, the definition of such children is not likely to be the same from any one state or program to another. We use medical terms like "a PKU child." We use physical terms like "orthopedically handicapped." We use psychological and psychiatric terms like "emotionally disturbed." We use judgments of inadequacy like "handicapped." We use some educational terms like "learning disability" but with sometimes even less precision than in the noneducational terms.

Few of us have given attention to the need for linguistic precision in dealing with the many concepts in our field of special education. Dr. Godfrey Stevens and Dr. Thomas Jordan are among those who have given the matter some attention but seem to have had relatively little impact upon the nation.

It would be my preference to convert our terminology into educational language for educational purposes. This, I think, can be done by referring to handicapped children as they are now known as children with learning disabilities. Two simple major categories would exist: (1) children with general learning disability varying in degree or severity which would include most of those now called mentally retarded, and (2) children with specific learning disabilities. Actually it would be a classification or a taxonomy of disabilities rather than of children. Any one child might have more than one of the specific disabilities and indeed may have general learning disability in addition to one or more of the specific learning disabilities.

This kind of system, it would seem to me, would permit us to begin to do more in the way of precise diagnostic work and precise prescriptive work in relation to the discovered learning disability. It would also more clearly differentiate the role of the school from the role of medicine or of other community agencies. My advocacy of this point of view has at least had one small amount of impact in that the Bureau of Education for the Handicapped is now using "specific learning disability" instead of "learning disability" in its reference to whatever group of children this includes.

OTHER LIMITATIONS

I should now like to talk about several aspects of our scientific limitations. One, certainly, is our instrumentation for diagnosis. We have heard advocates of abandoning IQ testing but rarely, if ever, a suggestion for an effective next step. Of course, tests of IQ are not as precise as test of height or weight. If used in a sophisticated manner, however, they are all but indispensable to our discovering the limitations of the child relative to many if not most academic tasks. There are efforts under way now to develop scales of adaptive behavior to help us get at some dimensions of the child not revealed by the typical and traditional psychological and educational testing instruments. We are still a long way from the complete personality inventory, and it may have to be done electronically. Early efforts in this direction are under way through the assessment of the impact of electrical discharges from the brain immediately after exposure to light flash. This, of course, provides no hope for such assessment applied to the blind.

Another aspect of our scientific limitation has to do with what is known as the knowledge gap. Woodring and others have referred to the apparent lag of 25 to 50 years between the discovery of knowledge and its application in the school system. I like to think that this gap is narrowing and nowhere more so than in special education. Yet a major project in which I was involved last week was planning to translate research to the teacher in such a way that she could become and would become more effective in dealing with exceptional children in the classroom.

Of overwhelming significance in the social aspects of science is our society's failure to apply knowledge which would prevent many handicapping conditions. I refer you, for example, to MR67, report of the President's Committee on Mental Retardation. This report clearly shows that some 75 percent of mental retardation is of socio-environmental etiology.

This was followed by MR68 which said:

> Three-fourths of the nation's mentally retarded are to be found in the isolated and impoverished urban and rural slums....
>
> A child in a low income rural or urban family is 15 times more likely to be diagnosed as retarded than is a child from a higher income family.
>
> ...the conditions of life in poverty--whether in an urban ghetto, the hollows of Appalachia, a prairie shacktown or on an Indian reservation--cause and nuture mental retardation.

What are the specific culprits? Fairly well identified are linguistic deprivation, deprivation in "anchoring" to a normal home-parent complex, deprivation in medical care, pre- and post-natal, and malnourishment.

So perhaps this is not "scientific" but "social" limitation. It is the greatest one. Education typically gives too little, too late--only 18 percent of a child's waking hours in school each year and not beginning until age 5 or 6.

The Handicapped Children's Early Education Assistance Act, passed by the last Congress, symbolizes the effort needed. But so many who will be handicapped by school age are not ostensibly so at ages 1-5. Further, this Act which authorized $10 million this year is now slated for only $3 million in the tentative federal budget. While damage to an infant or a child through early deprivation may be partially reversible or remediable, its effects are likely never to be completely eradicated.

This brings us to the fourth limitation--finances. Manpower shortage for the special education effort can be traced to it. Inadequate materials and equipment in many special education programs can be traced to it. Failure to educate beyond the end of compulsory school attendance ages may be traced to it. Lack of special education follow-up services into the adult years is largely due to it.

I quote President Lyndon B. Johnson on our nation and financing education. It was on December 27, 1968. Several of us were gathered in the White House to present to President Johnson "Teacher in the White House"--a leather-bound summary of educational legislation passed during his tenure in office. It was an otherwise historic day. Splashdown of Apollo 8 was scheduled for 10:51 a.m. The President found it so difficult to leave us in spite of frantic signalling by his aides that he was actually late for splashdown. But while with us, he said about our investment in education, "They have been rather pathetic. We have shared relatively little of our resources and wealth with the system of education which we rely on to protect our system of government...we haven't even begun what needs to be done."

And where are we in special education funding in the current proposed federal budget? Authorizations by the Congress are some $14 million but recommended appropriations are more like $85 million. We must close that gap.

If there is a fifth limitation, it may be our propensity for comfort. We just seem to go on doing what we've been doing in the ways we've been doing it since we're comfortable that way.

APPENDIX

SPECIAL SCHOOL DISTRICT of St. Louis County Missouri

9820 MANCHESTER ROAD
ROCK HILL, MO. 63119
WO. 2-4567

BOARD MEMBERS
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WENDELL H. STARK, VICE PRES'DENT
LILLIAN M. FELLER, SECRETARY
CLEMENT A. COLE
WILLIAM F. ALLISON
ARMSTRONG B. CRIDER

ORAL W. SPURGEON
Superintendent

Dear Parents:

We offer you here some guidelines which might help you work more effectively with your child. We have reviewed the research about why some handicapped young men and women hold jobs and others fail to do so. In every instance, the most important things had to do with habits and personality --- even more than the severity of their handicap.

So what we try to do in school, and what we suggest you work on at home, is to help the child from a very early age achieve more and more of the following traits:

completion of chores and tasks --- correctly, promptly;

cooperation with other people --- sharing, respect for other people and their property;

consistent effort to do what is expected;

cautiousness --- safety consciousness;

accuracy and consistency in following directions;

dependability --- paying attention; increasing independence and responsibility; awareness of time and its importance;

emotional control --- control of temper and impulses resulting in improved concentration, "stick-to-it-tiveness", steady rate of performance, and increasing ability to tackle new tasks and attend to two or more tasks at the same time or without additional directions;

self-correction;

accepting authority --- from parents, teachers, others;

sociability --- good manners, acceptable public behavior;

good group participation --- teamwork; stimulated by competition; desire to do better;

good physical health, stamina, pacing self;

effective self expression, especially good speaking ability;

good grooming, habits of neatness of appearance, cleanliness;

good memory;

good hand and finger skills;

good judgment; makes correct decisions.

In addition to the development of these habits and attitudes, it is well to help the child acquire the following skills to the limit of his ability in addition to reading, writing, and simple arithmetic.

tell time
make change
arrange things in numbered order
arrange things in alphabetical order
tie knots and bows
use the telephone
use a ruler, a yardstick, a tape measure
use weight scales
sort things by size, by color, by shape
do simple cleaning
read simple dials, gauges, thermometers, etc.
use simple hand tools
do simple needle and thread sewing

Your child's teacher (and principal or supervisor) is a good source of help. If your child is lagging behind on one or more of these objectives, the teacher may know ways to help. Too, you don't want to push your child too hard, like in learning to tell time, until he has the ability to learn it. The teacher can help you determine when he is ready.

Another thing which we encourage you to do is to give frank answers to children's questions about most everything. Our teachers, like teachers all over the nation, are responsible for giving the children facts. This, of course, includes such things as the proper names of parts of the body, how the body functions including changes from boy to man and girl to woman, how babies are made, personal hygiene, family life --- the rules and laws about husband-wife as well as parent-child relationships. If you are not sure about the proper names of body parts or the facts of life concerning human reproduction and related matter, you may write, call or visit the Social Health Association of Greater St. Louis, Miss Helen Manley - Executive Director, 7803 Clayton Road, St. Louis, Missouri 63117, phone PA 7-1450 for pamphlets and other medically and educationally approved material.

If you would like a list of publications for parents of our kind of children, some of them very cheap, write for their list of publications to

N.A.R.C.
420 Lexington Avenue
New York, New York 10017

or call SLARC, phone MI 7-5190 (St. Louis).

Sincerely yours,

John W. Kidd, Ed. D.
Assistant Superintendent, M.R.

jwk;emr

SPECIAL SCHOOL DISTRICT of St. Louis County Missouri

9820 MANCHESTER ROAD
ROCK HILL, MO. 63119
WO. 2-4567

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Dear Parents:

Permit us to explain several things about our programs in mental retardation.

If your child is in a class for the educable mentally retarded, he will be given a nationally standarized achievement test each year --- usually in May.

No matter what type of class for the retarded your child is in, he is given an individual psychological examination about every three years. Occasionally a child improves so much that he returns to regular school and less frequently one regresses so much that he is no longer eligible to remain in school. Neither of these happens to most retarded children. Mental retardation is, in the vast majority of cases, a permanent condition.

The different states have adopted different words for "children whose ability to learn is less than about three-fourths of the ability of the average child of the same age". In Missouri, the law refers to them as "mentally retarded". In Illinois they are "mentally handicapped". In Ohio they are "slow learners". So, don't let the wording bother you. Really, they are children with "general learning disability". In Missouri the highest retarded group is called "educable mentally retarded". Most of the educable mentally retarded can become independent, job-holding adults --- about 3 out of 4 who stay with us to age 18 or so. The next group is called trainable mentally retarded. Few of them are capable of holding jobs but we are able to help most of them become partially independent in self-care and socialization and some learn to hold jobs though usually it is in a protected environment such as a sheltered workshop. The lowest group of retarded, the custodial or profoundly retarded, are expected to be life-long dependents and are not placed in schools.

It is important to remember that we are operating school programs. We cannot assign one teacher or assistant to one child. If a child does not meet our admission and retention criteria, the parents will be requested to withdraw him. These criteria are:

1) Chronological age shall be between six (6) and twenty-one (21) although if a retardate will reach the age of 21 before the school year is terminated, then he shall not be enrolled in that school year; however, if he will be 21 after February 1st, he may attend the first half of that school year, if the parent(s) requests it.

2) Prognosis for improvement is positive, such prognosis being based upon professionally acceptable evidence and made by the responsible educator(s); i.e., per statement by Missouri State Department of Education "through training in a group setting may be expected to acquire abilities and skills that will enable them to make a more satisfactory adjustment in home and community during adult life".

3) Health and physical condition shall be such as to meet State approved standards; free of contagious disease, and not unusually susceptible to injury or danger by school attendance.

4) Behaviors shall be such as to render group placement practical; specifically, the child shall be:

   a) continent; i.e., have control of bodily discharges; particularly urination and defecation;

   b) free of behaviors which are intolerably disruptive of group;

   c) able to communicate expressively and receptively so as to make wants and needs known and respond to necessary controls and directions; such giving and receiving of meaningful signals may be verbal, auditory, visual, gestural or kinesthetic.

5) In the event of doubtful prognosis for improvement, trial or diagnostic placement may be made.

6) Parents will be involved in all phases of planning for their child's school future, and their consent to their child's placement in the program(s) is necessary.

Remember, please, 1. if your child is in a class for the educable mentally retarded his mental age, academic readiness age, and judgmental age are about 1/2 to 3/4 of his chronological age. This means that an educable mentally retarded 10 year old can learn and think much more like a 5 - 7 1/2 year old.

2. if your child is assigned to a class for the trainable mentally retarded, his mental age is between 1/4 and 1/2 of his chronological age. This means that a trainable mentally retarded 10 year old thinks and learns more like a 2 1/2 - 5 year old.

Sincerely yours,

John W. Kidd, Ed. D.
Assistant Superintendent
Department for the Mentally Retarded

jwk:njf

SPECIAL SCHOOL DISTRICT of St. Louis County, Missouri

JOB READINESS EVALUATION CHECK LIST

Date Completed _____

Name _____ Social Security No. _____
(Last) (First) (Middle)

Birthdate _____ Sex _____ Race _____ Telephone Number _____

Address _____
(Number) (Street) (City) (State) (Zip Code)

Parent(s) or Guardians (specify) _____

Form filled out by (teacher's name) _____

District _____ School _____

Current Status:
Adol. II (final year) _____
Adol. II (next to final year) _____
MDE _____
TMR _____

Previous Job Training or Work Experience (including in school)
_____
_____

Approximate height _____; Approximate weight _____.

Please check in the spaces the statement best describing the individual as compared with other youngsters of approximately his (her) age and mental age.

	Well Above Average	Above Average	Average	Below Average	Well Below Average
OUTPUT (PRODUCTIVITY)					
COOPERATION					
EFFORT					
CAUTIOUSNESS - SAFETY CONSCIOUSNESS					
ACCURACY AND CONSISTENCY IN FOLLOWING DIRECTIONS					
DEPENDABILITY:					
Attendance					
Promptness					
Independence					
Awareness of time					
EMOTIONAL CONTROL:					
Concentration					
Perserverance					
Steady rate and adaptability					
New task; two or more tasks at once					
SELF-CORRECTION					
ACCEPTING AUTHORITY					
RELATIONSHIP WITH OTHERS:					
Sociability					
Teamwork					
Challenged by competition					
PHYSICAL STAMINA					
VERBALIZATION - Self-expression					
PERSONAL APPEARANCE - Grooming					
MEMORY					
MANUAL DEXTERITY					
CHOOSING - Decision-making					
SPEECH				*	*

*Describe: _____

VISION: Seems normal without glasses _____; with glasses _____.
Seems to have vision problem without glasses _____; with glasses _____.

Job Readiness Evaluation Check List

MOTOR LIMITATIONS:

		Normal	Mild Limitation	Severe Limitatio
A. Upper Extremities	Hands - Right			
	Left			
	Arms - Right			
	Left			
B. Lower Extremities	Feet - Right			
	Left			
	Legs - Right			
	- Left			
	Hips - Right			
	- Left			

Other physical deviations:

Has he used public transportation independently? Yes ____, No ____; if No, do you think he is capable of doing so? Yes ____, No ____.
Does he have a Missouri Driver's License? Yes ____, No ____; own a car? Yes ____, No ____.
Can he: read? Yes ____, No ____; write his name? Yes ____, No ____;
write simple messages? Yes ____, No ____; tell time? Yes ____, No ____;
make change? Yes ____, No ____; do simple counting? Yes ____,No ____;
arrange alphabetically? Yes ____, No ____;
arrange serially by number? Yes ____, No ____; tie knots and bows? Yes ____, No ____;
use a telephone? Yes ____, No ____; use a ruler? Yes ____, No ____;
use a yardstick? Yes ____, No ____; use weighing scales? Yes ____, No ____;
do simple sorting as by color or size? Yes ____, No ____;
do simple cleaning? Yes ____, No ____; read simple gauges and dials? Yes ____, No ____;
locate or identify things by number, color, etc.? Yes ____, No ____;
use simple hand carpentry tools? Yes ____, No ____;
use simple hand sewing equipment? Yes ____, No ____;
use a typewriter efficiently? Yes ____, No ____.

Does he adhere to acceptable standards of public behavior? Yes ____, No ____.

Can he fill out an application blank properly? Yes ____, No ____.

METROPOLITAN ACHIEVEMENT TEST SCORES - Date _____
Word Knowledge_____ Reading _____
Spelling_____ Arithmetic Problem Solving_____

What is his vocational goal(s)?_____
Is his vocational goal(s) realistic? Yes ____; No ____.*
*if No, why?_____

_____

_____

Please note factor's in this pupil's life or home which contribute to or detract from his progre s:

_____

_____

Teacher: Prepare original and a carbon copy upon request of Job Placement Consultant; forward original to M.R. Dept. at Central Office; place carbon copy in pupil's school file (central office will place original in pupil's file; place a photo-copy in Job Placement file, and send a photo copy to WEC on referral.)

MR JREC L 67

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